Illnesses ❑ Diabetes ❑ Heart Disease ❑ Asthma ❑ High Blood Pressure ❑ Emphysema
❑ Stroke ❑ Cancer ❑ Arthritis ❑ COPD ❑ High Cholesterol ❑ CHF
❑ Sleep Apnea (C-Pap machine?) ❑ None *List Others Below*

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Surgery ❑ Tonsils ❑ Appendectomy ❑ Heart ❑ Gallbladder ❑ None *List Others Below*

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Family History	Y	N	Relationship to Patient Mother Father Sibling Grandparent		Y	N	Relationship to Patient Mother Father Sibling Grandparent
Blindness				Heart Disease			
Glaucoma				High B/P			
Arthritis				Kidney Disease			
Cancer				Lupus			
Diabetes				Stroke			
Cataracts				Macular Degen.			

Review of Systems	Y	N	If YES, Please Explain
General / Constitutional (fever, weight loss, obesity, etc)			
Integumentary / Skin (rashes, growths, hair loss, etc)			
Ears (hearing loss, drainage, etc)			
Neck (swollen glands, thyroid, etc)			
Respiratory (congestion, wheezing, COPD, etc)			
Cardiovascular (high B/P, racing pulse, etc)			
Gastrointestinal (stomach upset, diarrhea, constipation, etc)			
GenitoUrinary (painful or frequent urination, impotence, etc)			
MusculoSkeletal (joint pain, stiffness, swelling, cramps, etc)			
Neurological (seizures, convulsions, numbness, headache, weakness, etc)			
Endocrine (bruising, diabetes, hypothyroid, etc)			
Hemato-Immunologic (anemia, high cholesterol, bleeding tendencies, etc)			
Psychiatric (anxiety, depression, insomnia, etc)			

Do you drink Alcohol? NO - If Yes: ❑ Occasionally ❑ 1/day ❑ 2-3/day ❑ 4+/day

Do you use Tobacco? NO - If Yes: ❑ Chewing ❑ 1 pack/day ❑ 1+packs/day

Patient (or Legal Representative) Signature: _____

***** **Please Complete Both Sides of this Form** *****